This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://das.nh.gov/hr/health_benefits_active.html or by calling Anthem at 1-800-933-8415.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** Member/**$1,000** Family for In-Network providers; **$1,000** Member/**$2,000** Family for Out-of-Network providers. Does not apply to preventive care, Site of Service, and other services. See below for details.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,000** Member/**$2,000** Family for In-Network providers; **$3,000** Member/**$6,000** Family for Out-of-Network providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-billed charges, and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call **1-800-933-8415** for the list of In-Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded** services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay/Visit	Deductible and coinsurance apply	——————none——————
	Specialist visit	$30 Copay/Visit	Deductible and coinsurance apply	——————none——————
	Other practitioner office visit	$15 Copay/Visit for Chiropractor	Deductible and coinsurance apply	Acupuncture is not covered. Coverage is limited to 24 visits per member per calendar year for Chiropractic visit.
	Preventive care/screening/immunization	No Charge	Balance over the maximum allowed amount	Coverage is limited to a Maximum Allowable Benefit for Out-of-Network providers.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible Applies	Deductible and coinsurance apply	Costs may vary by site of service. You should refer to your formal contract of

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	Deductible Applies	Deductible and coinsurance apply	coverage for details. Deductible for laboratory services waived if laboratory services are received at a Site of Service location.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Tier 1 - Typically Generic	$10 script at retail; $1/ script at mail	Your copay and any balance billing	Retail limit of 31 days; Mail service limit of 90 days.
	Tier 2 - Typically Preferred/Formulary Brand	$25 script at retail; $40/ script at mail	Your copay and any balance billing	Retail limit of 31 days; Mail service limit of 90 days.
	Tier 3 – Typically Non-preferred/Non-formulary and Specialty Drugs	$40 script at retail; $70/ script at mail	Your copay and any balance billing	Retail limit of 31 days; Mail service limit of 90 days.
	Tier 4 -Typically Specialty Drugs	Mail only; See retail copays amounts if filled 31 days or less; See mail copays if 90day supply	Your copay and any balance billing	Specialty medication available through preferred mail network only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible Applies	Deductible and coinsurance apply	Costs may vary by site of service. You should refer to your formal contract of coverage for details. Deductible waived if Site of Service location.
	Physician/surgeon fees	Deductible Applies	Deductible and coinsurance apply	Costs may vary by site of service. You should refer to your formal contract of coverage for details. Deductible waived if Site of Service location.
If you need immediate medical attention	Emergency room services	$100 Copay/Visit	$100 Copay/Visit	If admitted, ER copay is waived.
	Emergency medical transportation	No Charge	No Charge	——————none——————
	Urgent care	$50 Copay/Visit	$50 Copay/Visit	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Walk In Center	$30 Copay/Visit	$30 Copay/Visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible Applies	Deductible and coinsurance apply	——————none——————
	Physician/surgeon fee	Deductible Applies	Deductible and coinsurance apply	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 Copay/Visit	Deductible and coinsurance apply	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Mental/Behavioral health inpatient services	Deductible Applies	Deductible and coinsurance apply	This is for facility professional services only. Please refer to your hospital stay for facility fee. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	$15 Copay/Visit	Deductible and coinsurance apply	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder inpatient services	Deductible Applies	Deductible and coinsurance apply	This is for facility professional services only. Please refer to your hospital stay for facility fee. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	No Charge	Deductible and coinsurance apply	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	Deductible Applies	Deductible and coinsurance apply	Applies to inpatient facility. Other cost shares may apply depending on the services provided.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Deductible and coinsurance apply	——————none——————
	Rehabilitation services	$15 Copay/Visit	Deductible and coinsurance apply	——————none——————
	Habilitation services	$15 Copay/Visit	Deductible and coinsurance apply	——————none——————
	Skilled nursing care	Deductible Applies	Deductible and coinsurance apply	Coverage is limited to 100 days combined maximum per member per calendar year.
	Durable medical equipment	No Charge	Deductible and coinsurance apply	——————none——————
	Hospice service	No Charge	Deductible and coinsurance apply	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Deductible and coinsurance apply	Coverage is limited to one exam every calendar year.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Weight loss programs
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids (19 and over hearing aid maximum of $1500 for each ear every 60 months)
- Most coverage provided outside the United States. See **www.bcbs.com/bluecardworldwide**
- Routine eye care (Adult)
- Bariatric surgery
- Infertility treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-933-8415. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield
P.O. Box 518
North Haven, CT 06473-0518

Express Scripts, Inc.
Attn: Pharmacy Appeals
6625 West 78th Street
Mail Route BL0390
Bloomington, MN 55439

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,860
- **Patient pays** $680

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$30
Coinsurance	$0
Limits or exclusions	$150
Total	**$680**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,770
- **Patient pays** $630

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$550
Coinsurance	$0
Limits or exclusions	$80
Total	**$630**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.